Send completed form to: Stacey Fisher
Mark Trece, Inc.
2001 Stockton Road, Joppa, MD 21085
Email: sfisher@marktrece.com Phone 410-879-0060 Fax 410-879-6277

Short-Term Disability Claim Form

Instructions to Claimant: Complete all sections of the Claimant's Statement and the Authorization to Disclose/Release or Obtain Medical Records. Have your physician complete the Attending Physician's Statement. Return the completed form to your Employer. Your employer will complete the Employer Statement and forward the completed form to CoreSource.

Claimant's Statement

Full Name		Social Security Number
Birth Date	Occupation	Date of Hire

Address (No. Street, City, State, ZIP)

Home Phone	Work Phone

Did your disability arise out of your employment? ☐ Yes ☐ No	Is claim due to an Accident? ☐ Yes ☐ No If Yes, Date______________

If accident, describe:

Cause and nature of disability:

List other sources of income:

Type	Effective Date	Amount
Other employment		
Worker's Compensation		
Social Security		
Retirement		
Other		

The foregoing statements, including any accompanying statements, are true and complete to the best of my knowledge.

Claimant's Signature ______________________________________ Date ______________

Employer's Statement

Employer	Location	Phone Number
Date Last Worked	Has employee returned to work? ☐ Yes ☐ No If Yes, Date______________	
Date of Hire	Date sick/vacation leave paid through	Effective Date of Coverage
Average weekly earnings prior to disability		# of Hours worked per week

Brief description of occupation (or attach job description)

Remarks

Authorized Signature ______________________________________ Date ______________

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

Patient Name: ______________________ Street Address: ______________________

City: ______________________ State: __________ Zip Code: __________ Date of Birth: __________

I authorize: ______________________
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

Release to: **CoreSource**
P.O. Box 7948
Lake Forest, IL 60045-7948

Specify Dates or date ranges: ______________________

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a healthy authority, employer, school, or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health;
- Health care provided to me; or
- Payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided in the HIPAA Privacy Rule.

I authorize any licensed physician, medical practitioner, medical professional, psychologist, counselor, hospital, clinic, including Veterans Administration, or other medically related facility, pharmacy, government agency, Social Security Administration, insurance company, insurance support organization, employer, or any other holder of my personal health information documents, to release to **CoreSource**, claim administration for the self-funded Plan under which I am covered (Collectively referred to as "the Company") or its authorized representative, all requested information or records. This shall include but not be limited to, any information and health history including all consultation, diagnosis, prescriptions, treatments, tests as well as any information regarding drug and alcohol abuse. This shall also include any information pertaining to the treatment of mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. In addition, I authorize any employer, former employer, insurance company or insurance support organization to give any information or record it has about me, my employment, my employment history and income earnings to the Company.

Redisclosure Notice: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or may no longer be protected by Federal Privacy standards. I understand this information will be used to determine my eligibility for benefits and may be reviewed by claims, underwriting, legal or other Company personnel. I authorize the Company to release any such information to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal or medical services related to the self-funded Plan or claim, or any other public or private entity as may be lawfully required. The information provided to **CoreSource**, its subsidiaries or representatives is to be used solely for the administration of claim(s). A simulated, faxed or copied image of this authorization shall be as valid as the original.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits, on my decision to sign this authorization. I understand that if I agree to sign this authorization, I will be provided with a copy upon request.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive any person, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a crime or fraud and may be subject to imprisonment and/or fines.

I declare that all of the above statements on this claim are true and complete to the best of my knowledge.

I understand that I have the right to revoke this authorization at any time. I understand this must be in writing and addressed to the privacy officer of the above named facility. This authorization will be valid until coverage expires.

______________________ ______________________

Claimant Signature/Legal Representative Date

ATTENDING PHYSICIAN'S STATEMENT

Send completed form to: Stacey Fisher
Mark Trece, Inc.
2001 Stockton Road, Joppa, MD 21085
Email: sfisher@marktrece.com Phone 410-879-0060 Fax 410-879-6277

Name of Patient | Date of Birth

DIAGNOSIS / OBJECTIVE FINDINGS / SUBJECTIVE SYMPTOMS

(a) When did symptoms first appear or accident happen? ____________

(b) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", state when and describe.

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(d) Diagnosis (Including ICD-10 code)

(e) If pregnancy, est. date of delivery ____________

TREATMENT

(a) List all dates of treatment for period of disability.

(b) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify)

(c) Nature of treatment (Including surgery and medications prescribed, if any)

PROGRESS

(a) Has patient? ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient? ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?

(c) Has patient been hospitalized? ☐ Yes ☐ No

(d) Hospitalized from ____________ through ____________

PROGNOSIS

(a) Date patient became disabled due to present illness ____________

(b) When do you expect patient to be able to return to work?
☐ 1 Month ☐ 1 - 3 Months ☐ 3 - 6 Months ☐ Never

(c) If return to work date is determined, date to return to usual work ____________

(d) Patient was continuously disabled (unable to work)
From ____________ To ____________

(e) If return to work date is not yet determined, please indicate the date the patient's condition will be reevaluated. ____________

REMARKS

Please list any restrictions or limitations.

Name (Attending Physician) Print	Degree	Telephone	Fax

Street Address	City or Town	State or Province	Zip Code

____
Signature*

____
Tax identification #

Date ____________

***Note:** This form must be completed by a physician.